

5393

CERTIFICATE OF DEATH

Reg. Dist. No. 05385

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GREENSBORO		c. LENGTH OF STAY IN 1b 3 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS DENTON	
3. NAME OF DECEASED (Type or print) HARRIETT First Middle Last		4. DATE OF DEATH MAY 23 1961 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 9, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB H. KIRK		14. MOTHER'S MAIDEN NAME ELMIRA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Talmage Strong Denton Address Denton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of pelvis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 5, 1960 , to May 23, 1961 , that I last saw the deceased alive on May 22, 1961 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Stoneifer M.D.		ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 5/25/61	
PHYSICIAN'S NAME (Type) Charles H. Stoneifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF May 26, 1961	22c. NAME OF CEMETERY OR CREMATORY Penn Hill	22d. LOCATION (City, town, or county) (State) Penn Hill Penn.
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Stoneifer ADDRESS Denton Md.		24a. REC'D BY REGISTRAR DATE MAY 31 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kane

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

CERTIFICATE OF DEATH

Reg. Dist. No.

05387

5395

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DENTON</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. LENGTH OF STAY IN 1b <u>50 YR.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRY MICHAEL DETWILER, SR.</u>				4. DATE OF DEATH <u>MAY 9 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 2 1985</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ABRAHAM DETWILER</u>				14. MOTHER'S MAIDEN NAME <u>MARY CULP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MM FRANCES T. DETWILER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>1959-1961</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 91 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 25</u> , 1959, to <u>May 9</u> , 1961, that I last saw the deceased alive on <u>May 9</u> , 1961, and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Dawson D. George</u> M.D. <u>Denton, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Dawson D. George M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMONT</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore & Son</u> ADDRESS <u>DENTON</u>				24a. REC'D BY REGISTRAR <u>MAY 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: *John William Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *April 15, 1927*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Duration of illness: *2 weeks*
8. Name of attending physician: *Dr. J. H. Jones*
9. Name of funeral home: *None*
10. Name of undertaker: *None*
11. Name of cemetery: *None*
12. Name of interment: *None*

13. Name of informant: *John W. Smith*
14. Address of informant: *123 Main St., Birmingham, Ala.*
15. Signature of informant: *[Signature]*
16. Signature of physician: *[Signature]*
17. Signature of funeral home: *[Signature]*
18. Signature of undertaker: *[Signature]*
19. Signature of cemetery: *[Signature]*
20. Signature of interment: *[Signature]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one is necessary, please execute only one certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G288 6/6/61 iwk

Reg. Dist. No.

05388

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE NEW JERSEY b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PRESTON		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greip Farm, Tanyard		d. STREET ADDRESS 67X-3	
3. NAME OF DECEASED (Type or print) AUGUST First DEYOUNG Middle DEYOUNG Last		4. DATE OF DEATH MAY 30 Month 1961 Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 16, 1905
9. AGE (In years last birthday) 55 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN DEYOUNG		14. MOTHER'S MAIDEN NAME MARTHA HASCUP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. AUGUST DEYOUNG Address 441 ARDABLE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 months DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dawson D. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAWSON D. GEORGE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JUNE 2, 1961	22c. NAME OF CEMETERY OR CREMATORY CEC WASHINGTON
		22d. LOCATION (City, town, or county) PARAMUS, N.J.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Walter Moore How Denton		24a. REC'D BY REGISTRAR JUN 1 '61 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Newell	

MEDICAL CERTIFICATION

THE BYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

1. Name of Deceased
2. Age
3. Sex
4. Race
5. Date of Death
6. Place of Death
7. City
8. County
9. State
10. Medical History
11. Cause of Death
12. Manner of Death
13. Signature of Examiner
14. Signature of Coroner
15. Signature of Physician
16. Signature of Medical Examiner
17. Signature of Medical Director
18. Signature of Health Officer
19. Signature of Registrar
20. Signature of Clerk
21. Signature of Secretary
22. Signature of Treasurer
23. Signature of Auditor
24. Signature of Assessor
25. Signature of Collector
26. Signature of Taxpayer
27. Signature of Voter
28. Signature of Resident
29. Signature of Citizen
30. Signature of Subject

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5397

05389

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb Preston d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Preston			
3. NAME OF DECEASED (Type or print) First Fred Middle W. Last Edgell		4. DATE OF DEATH Month May Day 23 Year 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1875	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Wesley Edgell		14. MOTHER'S MAIDEN NAME Julia Christopher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-22-7365		17. INFORMANT Address Leona O. Edgell			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 181.D DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder- DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 min 4 years?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease - fracture rt. hip.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Preston, Md.			
21. I certify that (I) (this hospital) attended the deceased from 9-11-41 to May 23, 1961 , that (I) (we) last saw the deceased alive on 5-22-1961 , and that death occurred at 5:15 PM from the causes and on the date stated above.							
22a. SIGNATURE Harold B. Plummer		22b. DATE SIGNED M.D.		22c. PHYSICIAN'S NAME (Type) Harold B. Plummer			
22d. ADDRESS Preston, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF May 26, 1961		23c. NAME OF CEMETERY OR CREMATORY Choptank		23d. LOCATION (City, town or county) (State) Choptank Md			
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR DATE MAY 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

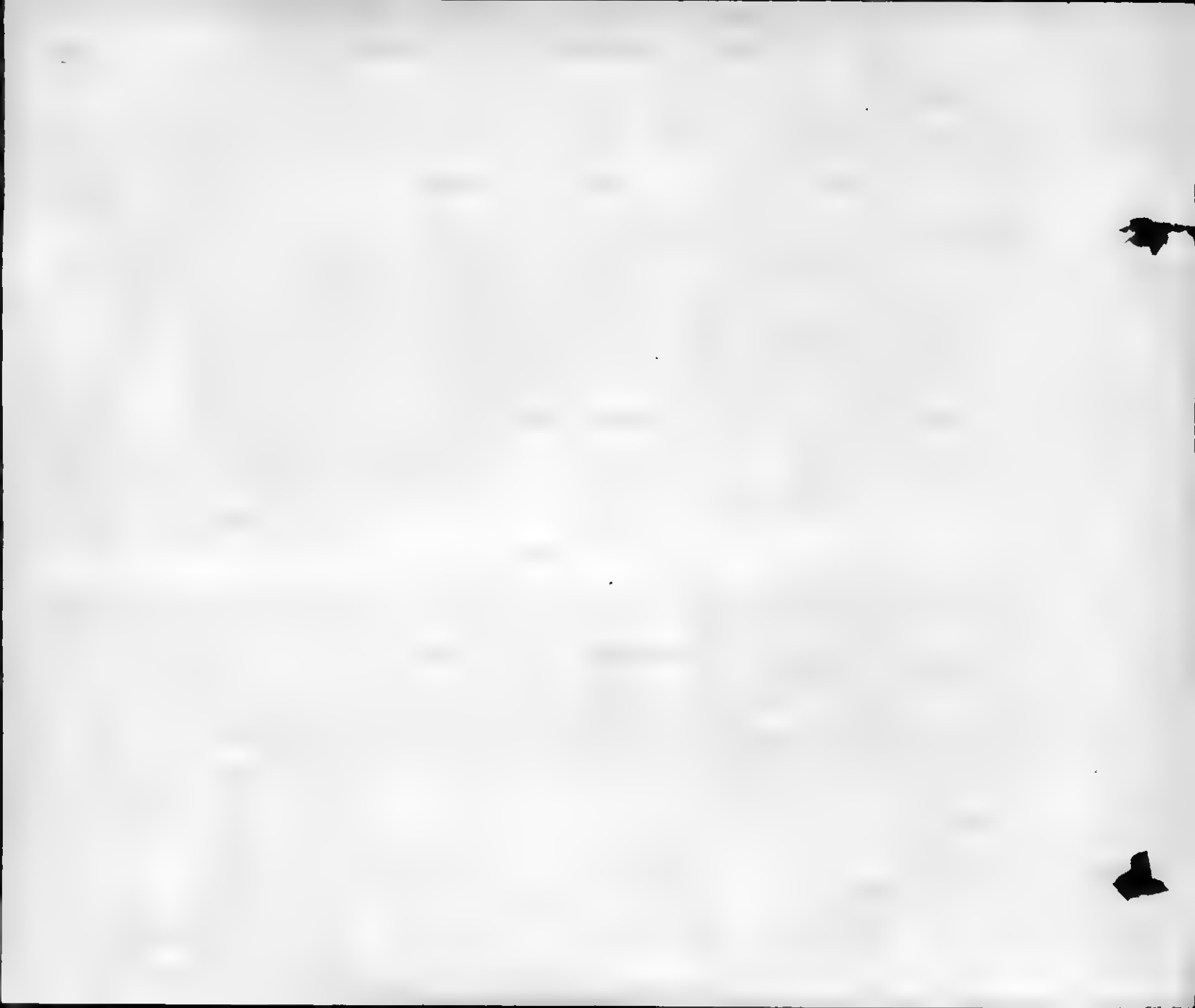
Reg. Dist. No.

05390

5393

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> COUNTY <u>PHILADELPHIA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL PRESTON</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILADELPHIA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>PAULINE</u> Middle <u>HOPKINS</u> Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JUNE 7, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RET. MERCHANDISING</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WALLACE HOPKINS</u>				14. MOTHER'S MAIDEN NAME <u>DELLA CLEAVES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>WALLACE HOPKINS, DENTON, MD</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head On Collision - Auto.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
DUE TO <u>Fractured Skull</u>				(b)			
DUE TO <u>Internal Injuries</u>				(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Highway - Route 16</u>			
20c. TIME OF INJURY Month, Day, Year <u>5-27-1961</u> Hour <u>5:30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>Rural Preston</u>		(County) <u>Caroline</u>		(State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dawson D. George</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dawson D. George M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>May 30 - 1961</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 30, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>			
22d. LOCATION (City, town, or county) <u>DENTON, MD</u>		(State)		24a. REC'D BY REGISTRAR <u>JUN 1 '61</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Angie Humberston Denton, Md.</u> ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>			

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

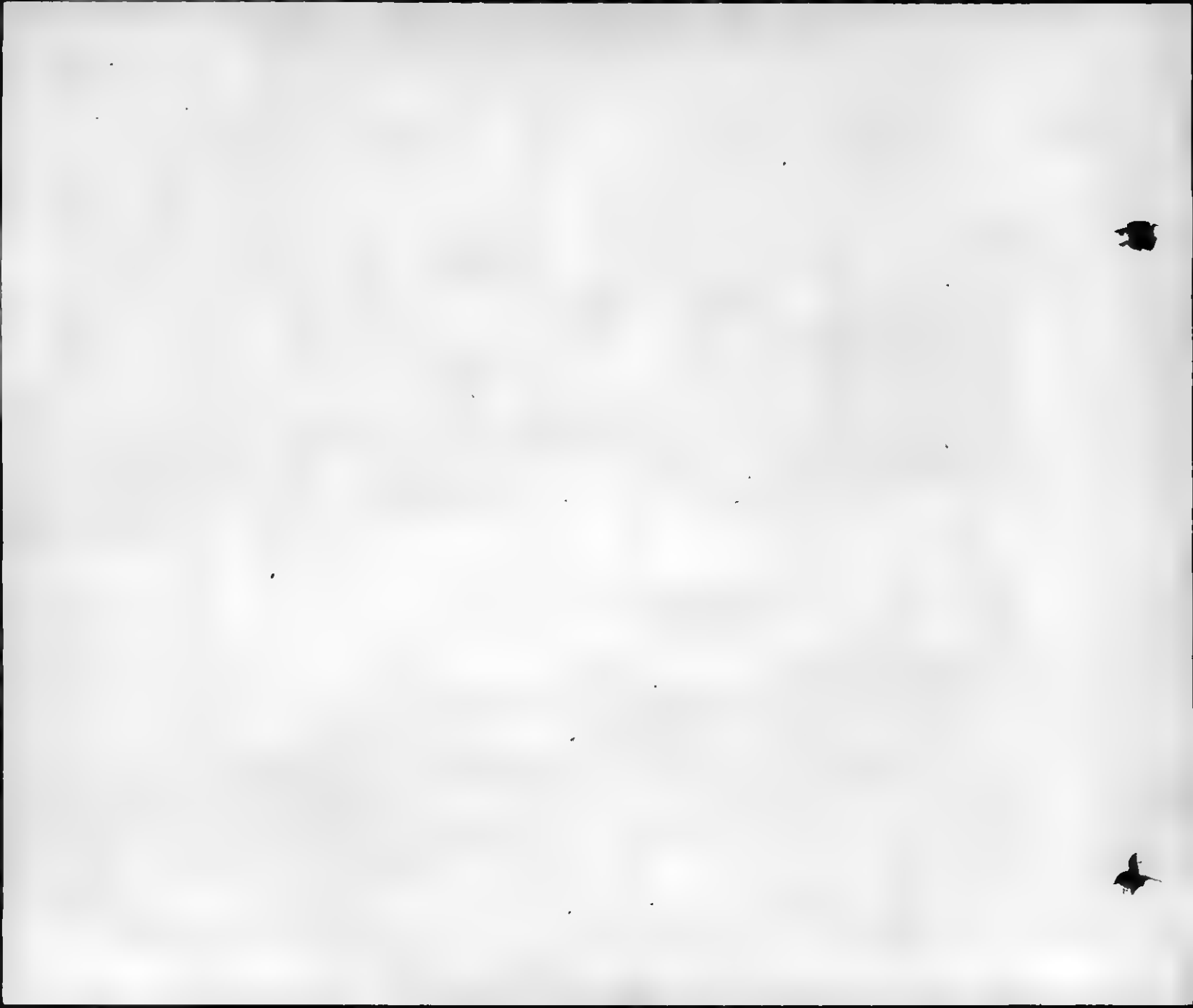
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05391

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PRESTON		c. LENGTH OF STAY IN 1b PRESTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle HOPKINS Last HOPKINS		4. DATE OF DEATH Month MAY Day 27 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 14, 1912
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALLACE HOPKINS		14. MOTHER'S MAIDEN NAME DELLA CLEAVE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT WALLACE HOPKINS		Address DENTON, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head on Auto Collision 816X DUE TO Crushed Chest - Internal Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. MULTIPLE FRACTURES DUE TO MULTIPLE FRACTURES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway - 16 - Route	
20c. TIME OF INJURY Month, Day, Year Hour 3:30 P. M. 5-27 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Rural Preston - Caroline Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dawson D. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dawson D. George M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 30, 1961	
22c. NAME OF CEMETERY OR CREMATORY DENTON		22d. LOCATION (City, town, or county) (State) DENTON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kline		ADDRESS Denton	
24a. REC'D BY REGISTRAR DATE JUN 1 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

DATE SIGNED

May 31-61



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05392

FOR STATE HEALTH DEPT.

5400

1. PLACE OF DEATH a. COUNTY <u>High Route 16-Dave</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN <u>Rural Preston</u> (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Preston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Hubbard</u> First <u>Hubbard</u> Middle <u>Hubbard</u> Last <u>Hubbard</u>		4. DATE OF DEATH <u>May 27</u> 19 <u>61</u> Month <u>May</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>May 18 - 1920</u>	9. AGE (In years or birthday) <u>41</u> yrs. <u>41</u> Months <u>41</u> Days <u>41</u> Hours <u>41</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rentury Farms</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harrison Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Hubbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-12-0142</u>	
17. INFORMANT <u>Edna Hubbard, Hurlock, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Automobile Accident</u> DUE TO (b) <u>Multiple Fractures and</u> DUE TO (c) <u>Internal Injuries</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Head On Collision</u>	
20c. TIME OF INJURY Month <u>5</u> Day <u>27</u> Year <u>1961</u> Hour <u>3:30</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>House 16</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rural Preston, Caroline Md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dawson O. George</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson O. George M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Ceme</u>		22d. LOCATION (City, town, or county) <u>Hurlock, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubbard</u>		24a. REC'D BY REGISTRAR <u>June 2 '61</u>	
ADDRESS <u>Cambridge, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11 08/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5401

05393

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. LENGTH OF STAY IN 1b 82 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adeline Middle Jackson Last Jackson		4. DATE OF DEATH Month 5 Day 9 Year 1961					
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1878	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Groce				14. MOTHER'S MAIDEN NAME Hester Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mabel Thomas Address 823 Bennett St. Wil., Del			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease with Chr. Myocarditis DUE TO (c) Disease with Chr. Myocarditis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 10, 1960 , to May 9, 1961 , that (I) (we) lost the deceased alive on May 9, 1961 , and that death occurred at 9 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Stoneifer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles H. Stoneifer, M.D.				22d. ADDRESS Greensboro, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-61		23c. NAME OF CEMETERY OR CREMATORY Thomas Burial Ground		23d. LOCATION (City, town, or county) (State) Ridgely, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais ADDRESS Greensboro, Md.				25a. REC'D BY REGISTRAR DATE MAY 15 '61		25b. REGISTRAR'S SIGNATURE Charles L. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

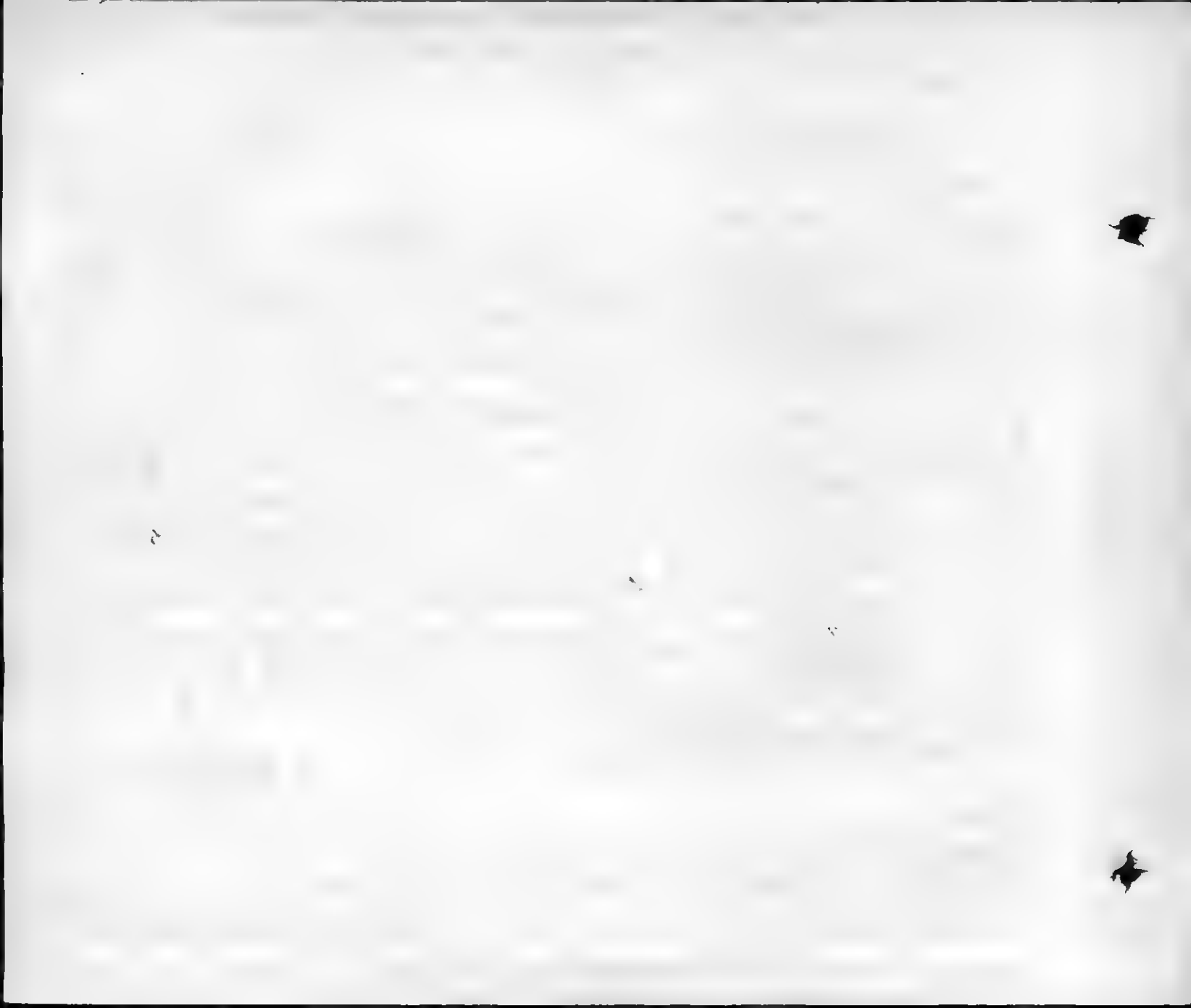
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05394**

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN lb 9 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle Larsen Last Larsen			4. DATE OF DEATH Month 5 Day 15 Year 19 61		
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1893	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 6 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Norway	
13. FATHER'S NAME Martin Larsen		14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 064-03-7386		17. INFORMANT Address Helene Bjerger Henderson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot Wound To Chest DUE TO (b) Arterial Hemorrhage DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun Shot Wound To Chest			
20c. TIME OF INJURY Month, Day, Year 5-15 19 61 Hour 5 o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) Henderson (County) Caroline (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 16, 1961	
EXAMINER'S NAME (Type) Dawson O. George		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-61		22c. NAME OF CEMETERY OR CREMATORY Greensboro	
				22d. LOCATION (City, town, or county) Greensboro, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleais		ADDRESS Greensboro Md.		24a. REC'D BY REGISTRAR MAY 17 61 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



VS A15 (4)
15M 9/55



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

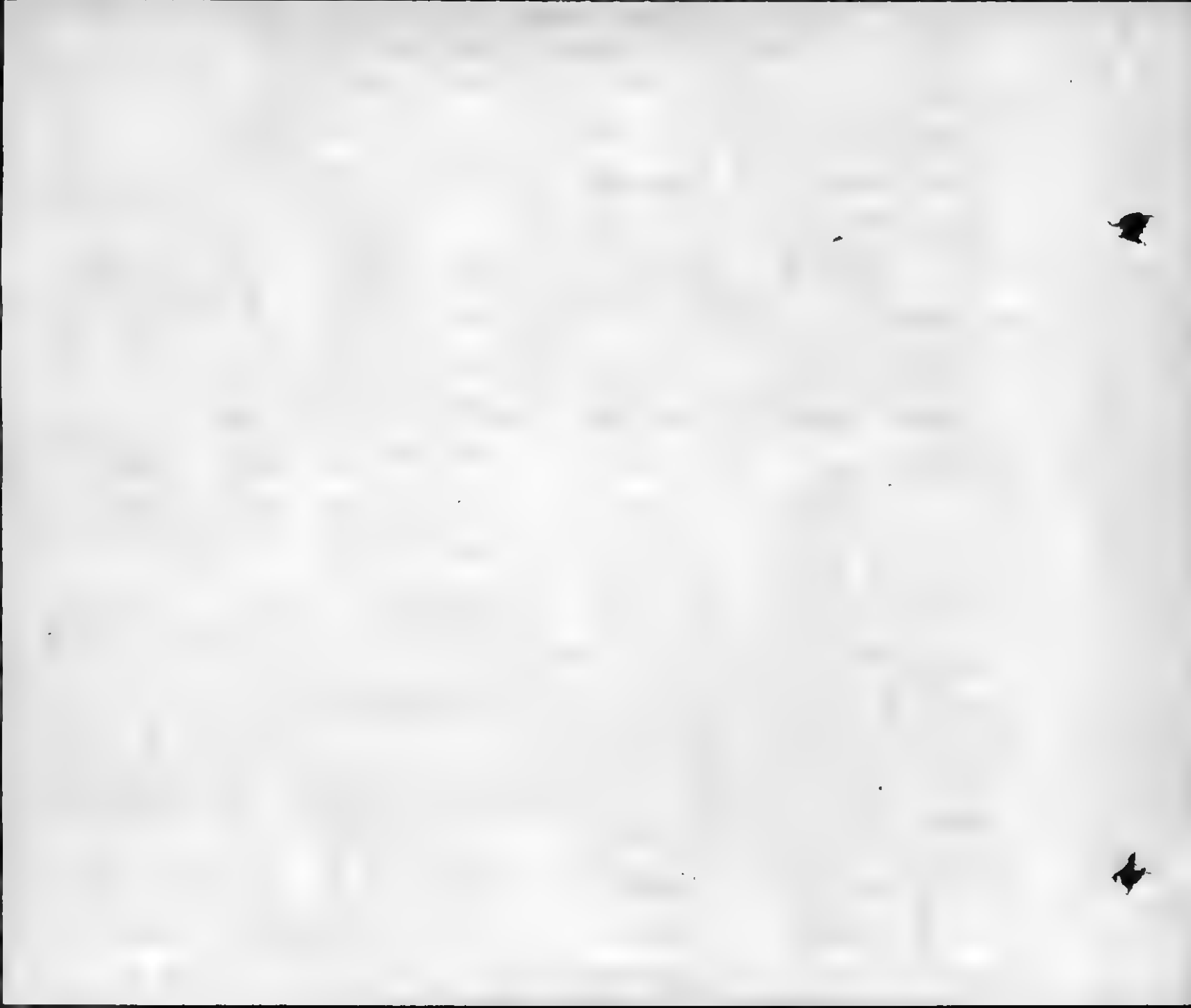
VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05396

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RIDGELY	
3. NAME OF DECEASED (Type or print) DAVID First MORGAN Middle LAST		4. DATE OF DEATH MAY 7 1961 Month Day Year	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1904 9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COLLECTOR		10b. KIND OF BUSINESS OR INDUSTRY JUNK	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WYLLIE MORGAN		14. MOTHER'S MAIDEN NAME CORELIA WILLIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. VALLIE CALDWELL, DENTON, MD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Acute 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) INTERVAL BETWEEN ONSET AND DEATH few minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dawson George M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 10, 1961	
EXAMINER'S NAME (Type) Dawson George M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 11, 1961	22c. NAME OF CEMETERY OR CREMATORY SPRING ROKE	22d. LOCATION (City, town, or county) (State) DENTON, MD
23. FUNERAL DIRECTOR'S SIGNATURE VIRGIL MOORE & SON ADDRESS DENTON		24a. REC'D BY REGISTRAR MAY 18 '61 DATE MAY 18 '61	24b. REGISTRAR'S SIGNATURE Clifton S. Hume

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05397

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission). o. <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>		c. LENGTH OF STAY IN 1b <u>10 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>ERVIN</u> Middle <u>NICHOLS</u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 14 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN L. NICHOLS</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE PRICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-5896</u>	
17. INFORMANT <u>Leon Nichols</u>		Address <u>Ridgely, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5th Degree Burns over body</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>few minutes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>7</u> Hour <u>o. m.</u> <u>4-6</u> <u>1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>His Home</u>	20f. (City or town) <u>Rural Denton County</u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson O. George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or MOVABLE (Specify) <u>Burial</u>	22b. DATE THEREOF <u>MAY 8, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Benulis</u>		24a. REC'D BY REGISTRAR <u>MAY 9 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05398

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Federalsburg c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bloomingdale Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg d. STREET ADDRESS River Road	
3. NAME OF DECEASED (Type or print) James Elmer Prattis		4. DATE OF DEATH Month May Day 19 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sand and Gravel	
13. FATHER'S NAME James Henry Prattis		14. MOTHER'S MAIDEN NAME Mary Jacobs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-09-3229	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4x20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		17. INFORMANT Lillie S. Prattis, Federalsburg, Maryland Address _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dawson D. George M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dawson D. George M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1961	
22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		22d. LOCATION (City, town, or country) Federalsburg, Maryland (State) _____	
23. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR MAY 25 '61	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

Denton, Md 5-22-61





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5408

05400

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Caroline Rural Henderson				c. LENGTH OF STAY IN lb 10 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Margaret		First Middle Strilcic		Last		4. DATE OF DEATH Month 5 Day 16 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1900		9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? Yugoslavia ✓	
13. FATHER'S NAME Frank Strilcic				14. MOTHER'S MAIDEN NAME Catherine Melcitic			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Katherine Marien Henderson, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA SEX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC NEPHRITIS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS			
						5 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-11 - 1961 to 5-15 - 1961 , that (I) (we) last saw the deceased alive on 5-15-1961 , and that death occurred at 6P M, from the causes and on the date stated above							
22a. SIGNATURE Robert H. Knight M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-17-61	
22c. PHYSICIAN'S NAME (Type) ROBERT H. KNIGHT M.D.				22d. ADDRESS GREENSBORO, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-61		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town, or county) (State) Near Greensboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie ADDRESS Greensboro, Md.				25a. REC'D BY REGISTRAR MAY 19 '61		25b. REGISTRAR'S SIGNATURE C. E. H. H.	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

054112

5410

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) VIOL T ANN TAYLOR			4. DATE OF DEATH May 7 1961		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 1, 1877		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME NELSON BLIZZARD		
14. MOTHER'S MAIDEN NAME LUCINDA CAPLE			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs Dolly Moore, Denton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. General atherosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 yrs 6 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept 1 , 19 58 to May 7 , 19 61 , that I last saw the deceased alive on May 7 , 19 61 , and that death occurred at 11 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Paul Knotts			DATE SIGNED 406 Market St		
PHYSICIAN'S NAME (Type) E. Paul Knotts M.D.			Denton, Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1961		22c. NAME OF CEMETERY OR CREMATORY Bethel Church	
22d. LOCATION (City, town, or county) Carrollton		22e. (State) Md		23. FUNERAL DIRECTOR'S SIGNATURE J. N. Moore & Son	
23a. ADDRESS Denton		24a. REC'D BY REGISTRAR MAY 10 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5411

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05403

State of Md. Death No. 6/2/61 000

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Denton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>U. 3 Box 77 - Denton</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>11</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rhoda</u> First Middle Last <u>WAYMAN</u>		4. DATE OF DEATH <u>MAY</u> Month <u>25</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles W. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lurenia Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>James L. Wayman - Denton, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hypertensive Heart Disease</u> DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>3 mos.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o m <u> </u> p m. 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Dawson O. George</u> M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) <u>Dawson O. George</u>		22d. ADDRESS <u>Denton Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>De Spring Grove Cem. Denton</u>	23d. LOCATION (City, town, or county) (State) <u>Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Ashwell</u>		ADDRESS <u>Easton, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
5412
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
65404

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton		c. LENGTH OF STAY IN lb 6 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Wheeler Last Wheeler		4. DATE OF DEATH Month 5 Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1875
9. AGE (In years lost birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hughes		14. MOTHER'S MAIDEN NAME Margaret Buckmaster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elizabeth Longfellow Greensboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c) Generalized Atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1961 to May 6, 1961 that (I) (we) last saw the deceased alive on May 6, 1961 , and that death occurred at 4A M, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonifer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-61	
23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulois		25a. REC'D BY REGISTRAR MAY 11 '61	
ADDRESS Greensboro, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1

For the purpose of the law, the death of the deceased is hereby certified to have taken place on the day and at the place above stated.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 36 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5413

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05405

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 70 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro	
3. NAME OF DECEASED (Type or print) Beniah First Lewis Middle Wothers Last		4. DATE OF DEATH May Month 4 Day 1961 Year	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wothers		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-7274	
17. INFORMANT Charles Wothers Address Greensboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4/20/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr. 24, 1961 to May 4, 1961 , that (I) (we) last saw the deceased alive on May 4, 1961 and that death occurred at 4:30 P. from the causes and on the date stated above.			
22a. SIGNATURE Chas. H. Stonestifer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Chas. H. Stonestifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-7-61	
23c. NAME OF CEMETERY OR CREMATORY Bursville		23d. LOCATION (City, town, or county) (State) Bursville, Del.	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Boulais ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR DATE MAY 9 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

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